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ABSTRACT

This paper discusses case studies of children psychologically disturbed by the death of parents or siblings. Illustrations of mourning facilitation were mainly gathered from 16 orphaned children, ages 3-14. Some techniques used in helping children mourn include: discussing physical details of the illness, discussing previous deaths of animals and people, encouraging full and controlled expression of thoughts on death, helping children perceive the emotional reactions of family members, and encouraging mourning directly. (SET)

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FACILITATION OF MOURNING DURING CHILDHOOD

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The Center for Preventive Psychiatry, from which this presentation stems, was created to assist adults and children in dealing with situational stresses and strains, so that the maximal degree of health and emotional growth could occur despite severe emotional burdens. Among the over two hundred persons who have come to the Center since it opened three years ago, many have been victims of severe sudden crises not involving object loss. Some have been children who were sexually molested, or who have been badly beaten, or who have witnessed murders in their families. Some have been involved in highly overstimulating experiences, such as romantic involvement with adults of the same sex, or incestuous relations within their own families. Some have been severely ill physically. Two of our child patients were themselves at death's door.

No patients have, however, attracted more of our systematic professional interest and consumed more of our professional energies than adults and children who suffer the sudden and then chronic strains of object loss. Never a momentary injury, loss of a loved person, we maintain is often a long-enduring pathogenic influence. It deserves preventive intervention whenever the loss has occurred early in life, and especially when the early loss is that of the child's parent.

For some years two of the authors have been interested in working with healthy orphans in order to develop techniques of primary prevention of mental illness. Data concerning the series of 18 untreated orphans shows that, as far as neurotic symptomatology goes, not many orphans are free of important symptoms. Nor does the Center for Preventive Psychiatry find that orphans referred even very shortly after bereavement and for purposes said by the family to be preventive are in fact often free of symptoms. Of the sixteen children on whom we can report some details today, the Center found the majority of those sixteen were already suffering recognizable symptoms of neurosis, and in some cases temporary psychosis. We have a growing impression that orphanhood is indeed a categorical damage from which children may successfully recover untreated, but that is also true of fractures of the bone. Apparently a break in a love relationship early in childhood usually needs help in healing. It is our position that means for healing such fractures in a child's love-life are extraordinarily undeveloped,

little used and indeed shunned.

This paper is essentially practical in its orientation to technique, describing several forms of treatment of bereaved children, with a minimum of theoretical essay. Probably the best definition of "mourning" for our current purposes is, "the totality of reaction to the loss of a loved object." We omit from this definition any immediate consideration of whether mourning can occur at various stages in childhood, and if so to what extent one or another investigator judges it has occurred, although such consideration is worthy of volumes. To simplify the task somewhat, because it is actually of extreme complexity, Freud's 1915 definition of the work of mourning (1) will be used, with no detailed reference at this time to the more modern contributions such as those of Bowlby (2).

Since considerable review of literature on childhood mourning, including the few clinical cases reported in the literature in any detail has been made elsewhere, a repetition will be avoided here.

It is assumed that the statistical work of Beck (3), Barry (4), the Klimans (5), Gregory (6) and others amply demonstrates the long-standing common sense impression of many clinicians working with children that death of a parent is a severe insult to psychological health. Especially when bereavement occurs during early childhood, there is an excessive incidence of psycho-pathology within a few months, and it endures noticeably throughout adult life. These matters have not been well established, using exquisitely controlled anterospective and retrospective series of non-bereaved children and adults from comparable social, ethnic, racial and economic strata. Therefore, we maintain there is much society and the individual has to gain by carefully attending to the problems of each orphan in the adaptation to his loss. Furthermore, the readily detected nature of this pathogenic factor makes it a prime target for the all-too-little developed field of preventive psychiatry.

Helen Deutsch's studies (7) suggest the problem, amidst all its kaleidoscopic complexities, includes excessive childhood defensiveness against the emotion of grief. This is especially pernicious when the child's grief is for a dead parent, and his defensiveness against affective charge may become a lifelong pathogenic style for a bereaved child. To the extent that Deutsch has correctly discerned a major

etiologic component in the emotional disorders following bereavement, one major part of the preventive task is to help release a bereaved child's sad yearning feelings and associated memories. This must be done in a fashion compatible with the child's defensive repertoire, his developmental state, and his life framework, so that he can experience further development and avoid fixation to the psychosexual stage at which the damaging loss occurred.

The illustrations of mourning facilitation we will now provide are gathered mainly from sixteen orphaned children treated with varying degrees of intensity at the Center for Preventive Psychiatry over the past few years. An interesting fact in itself is that a new private Center could treat a series of 16 young orphans in three years, and now averages at least one such referral every month. There is preventive value in the community's recognition that bereaved children need special help soon, and that a place exists where such help can appropriately and congenially be obtained. The children have ranged in age from three to fourteen years, and were bereaved for periods of a few days to as long as five years before coming to the Center. As with our control series, of which we will not say much today, most of the treated orphans were already symptomatic by the time they reached us. Two of the children, both pre-schoolers, were known to the therapist before the parental death occurred, so that some baseline knowledge was obtained. In addition to our data concerning 18 non-patient orphans studied over the past six years by two of the authors, we can draw upon another source of information about childhood bereavement--a family in which a dying child was treated by one author, while another of the authors prepared the child's two older sisters for the impending death and then facilitated their adaptation to the actual loss. Special attention is given by one author to facilitation of feminine identity development in the case of a maternally bereaved girl. Another author provides data concerning the inter-relationships of mourning problems with the multiply determined symptoms of memory impairment in a paternally bereaved boy, thus casting light on the statistically widespread problems of intellectual inhibitions among bereaved children by an in-depth study of an illustrative case.

Now to begin our survey of techniques already in use at the Center, sketching them swiftly within the limits available to this presentation, we will put first things first, and go from customary techniques to less customary.

PARENT GUIDANCE

Nothing can be more critical to the mourning work of a child than the mourning work of the adults around him, and their attitudes toward his work. A major part of the preventive and therapeutic task can often be efficiently focused on parent guidance. Because such guidance techniques are widely practiced and well known, we will not dwell on them in this sketch, except for some insufficiently appreciated and essential points.

Parent guidance in cases of childhood bereavement should include at least some check on the possibility that the parent may be out of synchrony with the very different mourning rhythms of her child. Forceful evidence of such dysrhythmia within a family is often found when a widow of one year is ready to remarry. She may need assistance to realize that her children are much slower than she to give up the lost object, because of their greater defensiveness in permitting the work of mourning to proceed. During latency mourning is apt to be particularly silent and slow. Throughout childhood the tardy pace with which the old object is decathected is one cause of the poor acceptance of substitute parents. It is one factor which accounts for the otherwise surprisingly higher incidence of certain psychopathology Gregory's large-scale study reports. Among families where the parent has remarried, there is actually a higher incidence of truancy, school failure, and school dropout than among families where the surviving parent remains single. We must take these unpleasant facts very seriously, as they come from indisputable antero-spective study over a decade with 10,000 school children. The unmistakable implication is that we must guide parents to help their bereaved children with utmost tact when a remarriage is impending. At this juncture, however, our sketch of technique need not dwell on what is already common practice.

The surviving parent also needs guidance and support to avoid surprisingly common tendencies to use the child as a partial replacement for the lost spouse. Our series of 18 non-patient orphans (5) showed that seven out of eight families had one child who was chosen as bed companion for the surviving parent. Nine out of 18 untreated orphans began a pattern of bed-sharing with the surviving parent. This occurred in families which had no previous pattern of inter-generation bed-sharing. A six year follow-up showed that the tendency, generally manifest within a few weeks after bereavement, continues to be a major one.

It is unquestionably an obstacle to full mourning, in the sense of moving on to healthy substitutes for the lost object. One of the initial study's bed-sharers, then age eleven, is now 17 and over six feet tall. He has an active adolescent heterosexual life, but still shares the mother's bed several times a week!

Noting that a large fraction of bereaved children become parent bed-sharers, we can speculate reasonably that the incestuous impulses of most bereaved children--particularly when the bereavement is of the same sex parent--are a major obstacle to the progress of mourning. To mourn and be thereby freed for the loving of other persons is dangerous when the most available other person is the surviving, opposite sex parent who is also a tempting bed partner.

Bed-sharing is of course only one form of erotically tinged distortion of parent-child interaction after a death in the family. One 16 year old girl, who began treatment two weeks after the death of her mother from breast carcinoma, found herself in severe strain. She had been rather circumspect about undressing in front of her father, so long as her mother was alive. Now she was inclined to experiment with her father's reactions when walking around in her bra and panties. She wanted to check on whether her new behavior increased the frequency with which he displayed a nervous fly-touching mannerism. In this case, the child's developmental status permitted interpretation of her own erupting yearnings for closeness to the surviving parent via assumption of her mother's sexual role. Simultaneously, guidance of her father in providing the still necessary circumspection and structuring of his interactions with the excited girl permitted her to enter a vigorous and affectively profuse pre-occupation with memories of her mother. Mourning was to that extent facilitated, because it was less dangerous to decathect the lost mother when the child's super-ego could be supported as the mother had once made possible.

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<u>A Case of Learning Inhibition and Memory Disturbance Related to Pathogenic Mourning</u>:

Continuing with work which is often done well in any psychoanalytically-oriented, multi-disciplinary setting, we come now to one of the most familiar problems of bereaved children--a combination of intellectual disinterest, learning difficulties, and disturbances in the field of memory. Such bereaved

children are to be found in every grade school, out of proportion to their expected frequency among underachievers. Their treatment can be modeled on a standard psychotherapy, but in order to be successful, special factors must be considered, some of which are clearly seen in the following material.

The case of Richard* was selected to illustrate, first, that the patient could engage in a process similar to that of mourning in the course of weekly psychoanalytically-oriented psychotherapy sessions over a period of 16 months. It also appeared likely that the therapeutic facilitation of mourning helped neutralize the patient's impaired, conflicted memory sphere, freeing it for further development.

The patient had been referred at the age of 8 for treatment because of failing grades, inattention, and restlessness at school. Immaturity and a tendency to forget what he was about to do was noted by his mother to have become exaggerated following the death of his maternal grandfather the summer before. The grandfather's death was the last of a series of separations and losses experienced by Richard. Early in infancy his mother had been briefly hospitalized because of phlebitis. When he was four and a half years of age his father was discovered to have lung cancer and underwent surgery. During the following year, the cancer metastasized to the brain and Richard's father died. During the course of the next two years, the patient's older brother married and moved to another state, while his sister left for an out of town college. Richard's mother had returned to college, obtained a Master's degree and worked at a position that required occasional out-of-town travelling.

The patient impressed us as an alert looking, articulate, and socially responsive boy. His initial sessions communicated a sense of restlessness with an apparent nonchalance and bravado that barely concealed his anxiety and tension. He believed treatment had been recommended because "he gets mixed up a lot," would learn a spelling word and then forget it. He revealed he even forgot how to spell his name when he was in first grade. Other references to forgetting included not knowing when his mother was due to leave for or return from a trip. A relationship between object loss and the loss of information was suggested by Richard's concern that a classmate,

* Treated by Betty Buchsbaum, Ph.D.

on whom he depended for information, might not be in his class the following years.

Another prominent symptom related to his memory difficulty occurred in the form of "slips of the tongue." Those slips tended to be more closely bound to references to illness and death than was the more general forgetting phenomenon. Thus, Richard referred to an ambulance as an "alabance." Again, when describing a game he used to play with his father he used the word "internal" instead of air-terminal.

There was also evidence that when Richard did recall emotionally significant content he did so in a rather primitive, and immature mode. Remembering was often achieved in a visually-oriented context rather than through verbal expression. The tendency to use relatively primitive mechanisms to deal with memories was considered a function of the strength of the affects still attached to the ideas so expressed. The phenomenon included relatively benign events such as projecting onto a tree branch outside the office window the notion of a man's arm. Once Richard was momentarily confused when he almost misidentified a man who resembled his father and thought the man to be his father. Richard also reported that he occasionally saw things as appearing smaller and more distant than they were, as well as larger and closer. He then associated the feeling of distance to the notion of people leaving or dying. In the following session his comments led the therapist to speculate about his desire for his father to be alive again. Richard revealed that he had actually experienced looking at his father who had appeared as a "very small man in the kitchen cabinet." This hallucination had occurred the previous year, with Richard's awareness of its imaginary nature. It would seem those thoughts and memories which were still too intensely cathected to be considered in a rational, secondary process mode could better be allowed expression in the visual sphere, where hopes and wishes might still be concretely experienced.

Let us now examine the proposition that the mourning occurred, that fantasies and memories associated with his father's death were gradually worked over, partially decathected, and usefully re-assimilated by Richard. In addition, let us see if this therapeutic work did facilitate a reorganization and further growth of the memory sphere.

Richard's references to his father's death were initially expressed via personally remote, destructive, and elaborately dramatized fantasies. Man-crushing trucks and explosive fires were among the prominent instruments of death. By the fifth month of treatment, and no doubt significantly following a vacation from treatment, there was a marked reduction in explosive and destructive themes. Richard began to express fears about his mother's welfare and disclosed dreams and thoughts about monsters. Simultaneously he began to describe detailed memories of the course of his father during the terminal illness and death. Games such as checkers and block-play elicited a growing number of associations and increasingly distinct reminiscences concerning his father's activities before his illness. Details about his physical deterioration were repeatedly described with increasing clarity, as with a blurred image coming into focus. Finally, in the 37th session Richard spontaneously listed all the things he could recall about his father. His inventory included the fact that everyone in his family was sad at the funeral. This reference was Richard's first attempt to admit his own unhappiness. The fear of his inability to control his sadness was reflected in the next session when he created a story about a boy who flooded his home with his tears. The boy attempted to cover his eyes but then tears escaped from his ears and mouth. When the boy stopped up these openings, he experienced such pressure that he thought he would crack up. Then Richard went on to tell how the boy left home because of the flooding and cried for 200 years, flooding a complete desert. An Indian shot the boy for ruining the ground with his tears. In view of these associations to sadness, Richard's comment that remembering his father's illness "just causes trouble" is only too understandable.

However, six weeks later Richard was able to explain that he could now remember well enough but didn't report his memories because doing so "would get him down." Concommitantly, he demonstrated his excellent skill in playing "Concentration," a memory game. It was considered to be more than a coincidence that on this same day Richard complained that he didn't see why he was in treatment since the therapist could not bring back his father. The patient, here, reluctantly relinquished hope for his father's return. In doing so, the incipient expression of the mourning process was further advanced. Richard's ego had entered into the task that Freud described as severing its "attachment to the non-existent object."

As he did so he could go on to enjoy exhibiting his memory in the context of the concentration game. Reality gratifications now began to compete more successfully for Richard's attention.

A major part of the treatment work concentrated on transference reactions. When he felt abandoned by the therapist because of a temporary break in treatment, he perceived the therapist as very far away, although the seating arrangement was unchanged. The perceptual illusion reversed when the underlying sensitivity to loss was genetically interpreted, ultimately with reference to the father's and grandfather's death.

In support of the speculation that Richard could devote his energies more directly to the demands of his environment are the following data. Following the first year in treatment his reading level rose from a first to third grade. His teacher reported improvement in executing his assignments and increased interests in science and social studies projects. Comparison of WISC scores obtained after 16 months of treatment revealed a Full Scale I.Q. gain of 12 points. The three subtests contributing most to the increment were Comprehension, Similarities, and Picture Arrangement. The findings suggested an improved ability to conceptualize verbally and to deal more meaningfully with social interactions. At home, too, Richard became more cooperative and independent. In addition, an element of enthusiasm replaced the avoidance usually evoked by school assignments.

The lifting of constriction and increased independence and sociability were equally evident. Richard's growing capacity to face and undertake the work of mourning is believed to be a significant factor in his increasingly successful engagement in memory-related tasks. Richard seemed no longer required to use his memory as a wish-dominated vehicle which held on to his father's image. Rather, as he began to acknowledge and master his overwhelming experiences of pain, anger and sadness he was able to register the daily events of his life and participate in them with freedom and even pleasure.

<u>When A Sibling Dies</u>:

Here we move further into uncommonly encountered or sought after technical problems. The Center has worked with four children who experienced recent

sibling bereavement or were seen in advance of such an experience. In one family, Charles was dying of leukemia. His treatment in The Cornerstone Project has been described elsewhere (5). A principal feature of his work was that he emerged from a state of regressed clinging to his mother at age four and a half, a state which had been precipitated six months earlier by his initial hospitalization for leukemia. He had begun experiencing feminine impulses and transvestist tendencies, with girlishness of gait, voice, and mannerisms. It was impressive that, as he was able to talk very frankly with the analyst about reality matters, these severe psychological symptoms cleared entirely. The Cornerstone personnel were particularly moved by the child's ability to state that he knew he was going to die. We were sustained in our own anticipatory grief by the fact that the child's new-found ability to make such truthful statements was associated with marked clinical improvement and strengthening of his character.

At age six Charles died in the hospital. To the end he maintained a matter-of-fact assertive attitude toward his own medical management, including even the ultimate moment of his death.

He kept realistic watch over his oxygen supply, and on two occasions noticed when it was deficient, calling attention to his own vital needs to make sure they were cared for. As he gasped his last breath he was with his mother, to whom he said:

> "Mommy, I think I'm dying now. You better call the doctor."

We were all fortified by the astonishing courage of this at first weak and then very strong little boy to face the reality of his own death. Now we wish to report preventive work which was done simultaneously with his sisters.

Charles had two sisters, Barbara and Carol. At the time his leukemia was first diagnosed, they were six and eight. Both sisters were relatively healthy emotionally despite their brother's problems, and despite the fact their burdens were magnified by marital discord and a divorce. Their parents' divorce occurred just as Charles' leukemia was discovered. At that time, Carol developed a transient symptom, while Charles was still in the hospital for diagnosis. She began to pilfer from family members. Several psychotherapy interviews cleared the problem. But two years later, the mother agreed that preventive

intervention was desirable for both girls, despite their continuing good functioning. The mother was in guidance and therapy herself, but for this essay's purposes, little will be described of that important task.

It was decided that during Charles' terminal months that both sisters would be treated by one therapist. This decision was partly made on administrative grounds. At that time only one therapist with open time was eligible for seeing the children under their Medicaid coverage. From the outset, preventive treatment for both girls, who were interviewed separately, could be categorized from at least five points of view so far as the initiation of mourning occurred. These were, first, active forthrightness by the therapist; second, a stimulation of "immunizing" discussions when material was ripe; third, direct encouragement of catharsis; fourth, recurring emphasis on reality; fifth, direct encouragement of mourning.

Both Barbara and Carol were dealt with forthrightly from the outset. The relation of their presence at the Center to the seriousness of their brother's illness was elicited from them early. A dialogue then ensued about the physical details of Charles' condition. In Carol's treatment, this forthrightness led to much discussion of the previous deaths of pets, and her own advice that children are less upset about such events if they are told the truth right away.

Immunizing discussions were conducted, in the sense that the imminent loss was affectively experienced in small doses by discussions of the previous deaths of animals and people known, but not emotionally important to the girls. As they brought up such material, the slightest reference to Charles was underlined by the therapist. Cats, dogs, and goldfish were frequently known by the girls to die. Sadness was evoked, and sometimes there were reproaches for mistreatment of the animals. Barbara, who with her lesser tolerance for sadness also tended to projections of any guilt, bitterly accused her sister of having played aggressively with the family's dog shortly before it died. There was clear echoing of this guilt and sadness laden theme in a later session concerning reproaches to the sister for similar aggressive play with Charles. With small doses of guilt and sadness being liberated, the two sisters gradually became freer to complain about their mother's neglect of them in favor of Charles.

Catharsis should ideally be both full and controlled, so that a child need not undergo severe regression under the load of affect. Carol felt a temptation to become like Charles and complain about physical pains, experiencing this temptation strictly at a fantasy and discussion level. She had good insight into her desire for more of mother's attention. She also became aware, with the therapist's interpretation, of a wish that Charles would die and get the family's suffering over with. This expression of death wish was well balanced by an awareness of her affection for Charles and desire for him to get better. Much work was done to help the girls realize the developmental appropriateness of having opposite feelings about one person. Barbara's catharsis was more of angry feelings, but also of sadness, with many thoughts of vengeful ghosts apparently representing projected angry impulses mixed with sad ones. One aspect of the work was to encourage the girls to stay with and not run away from their feelings during treatment. It was hoped to help strengthen the ego's power to bind painful affects. This is a maneuver independent of the interpretation of the affect, and may be regarded as an exercise in defense-strengthening or tolerance-building somewhat like immunization. When the maneuver was performed, some higher level defensive manifestations were noted in Carol particularly. By the end of one such session, she showed signs of strong sublimative interests involving rescue fantasies and becoming a scientist who could cure diseases.

Reality orientation, the fourth of the five categories to be touched on in this summary of the girls' treatment, was oriented especially to the details of Charles' condition. The therapist attempted not only to help the girls report their own perceptions of changes in Charles, but also to understand the emotional reactions of others in the family to these changes. The emotional climate in the family was a matter to which the girls needed to adapt, and the therapist used every clue.

Barbara was less able than Carol to report her perceptions. Carol observed subtle changes in Charles, whom she described as "skinnier...his eyes looked like they were out...they weren't really out, but they looked bigger." With Barbara, who used avoidance of reality detail quite strongly in her sessions, the therapist was gently persistent. He was especially careful and especially persistent when Charles actually died. At that time the concern was that Barbara might make the event unreal or dream-like, and an

effort was therefore made to have Barbara exert mastery by actively recounting all she could of what she knew and had experienced, an effort to which she was able to respond collaboratively.

With Carol, much work was done on a more abstract kind of reality-orientation, concerned with the finiteness of life. In the final three months of Charles' life, Carol gradually softened her wishes for her own infinite survival, and began describing finite lives. At the same time she began speaking of the uselessness of Charles' medication, and how they were being discontinued, as well as how Charles was growing sicker.

The fifth category of special work, direct encouragement of mourning, had many aspects. Partly it consisted of establishing an atmosphere in which memories were an encouraged subject of discussion Partly it had occurred in a displaced way through affective discharges over other losses. A therapeutic alliance was easier for the older sister in this regard. Barbara's lesser maturity led to more avoidance and conscious suppression of remembering and feeling sad. Some of the appropriate affects were expressed by displacement into the transference. She was very somber in the session just before Charles' funeral was held. She lingered in the office and wouldn't budge when it came time to leave. The lingering was interpreted as related to how hard it would be to say "goodbye" to Charles the next day, to someone whom she loved very much, and that all kinds of saying goodbye were then hard. Barbara then remained still more sadly and quietly in her chair, and said that she had cried after hearing of Charles' death, and had been thinking of Charles while dying. When the therapist interpreted that some goodbyes and some remembering can take a long time, and crying can happen from time to time afterwards, or sadness without crying, the child was finally able to move, although with hesitation. She was apparently in the throes of depression, with vegetative signs in the sense of locomotor retardation.

Carol was more open, frequently crying tears with her family, frequently bringing up specific memories of Charles' life. She brought the therapist pictures of her brother. A month after the funeral she reported that she still got sad, but didn't cry any more, in fact did not think she could cry even if she wanted to.

Barbara's defensiveness was more rigid, and she would often spend part of her sessions looking out the office window at events on the street. Her last session is noteworthy in respect to ability to suspend the defensiveness.

> "She became quite depressed when I pointed out how hard it was for children to look at what was happening inside them because it might hurt a lot. At this point she began to give forth one memory after another about Charles, finally describing how neighborhood kids had trampled down some of Charles' flowers recently and how they all had died. Saddening a little as she recollected, she added that the flowers would probably grow out again because the seeds were still in the ground. She would plant an onion and watch it grow. I reflected to her about how nice a wish it was that Charles' flowers grow back again and that people also have wishes that brothers who die could also grow back again or be alive again just the way flowers might. She immediately corrected me and said, "No, not like a flower, like a tree." I said that one of the reasons she might want to grow that onion was to express her wish that Charles could have kept on growing ...and didn't have to stop. She replied, "I never thought of it like that before."

For brevity's sake we will close this section of the account, and leave for another essay a more complete version, with a follow-up of the children's condition and material from related cases of sibling bereavement.

Mourning and Facilitation of Feminine Identification in a Maternally Bereaved Girl:

Here we find a problem not uncommonly encountered in child treatment centers, but seldom sufficiently thought through. Marie Bonaparte, who grew up motherless, described the multiform consequences extensively (11). We had the opportunity to treat several maternal orphans who were girls and therefore severely burdened in the development of their own sexuality. A child whom we first saw after years had passed since the death of her mother was Norma, then ten and a half. Her mother had died five and a half years before. It proved feasible nevertheless to induce some long overdue mourning. Norma then came to grips with developmental tasks

which had been retarded in apparent consequence of the earlier strains. The precipitating problems leading Norma to treatment were an episode of physical complaints appropriately recognized by her father and stepmother as hysterical manifestations. The episode included generalized warm body feelings, trembling, tingling sensations in all extremities, and inordinate clinging to her stepmother whom she repeatedly asked "do you love me." Norma was underachieving in school, hesitant and slow in speech, sparse in vocabulary, and desirous of being a nun so that she would not marry. Her peer social life was constricted. History revealed there had been many pre-disposing or co-pathogenic experiences prior to the mother's death due to carcinoma of the pancreas. The death occurred rapidly over a one month period following diagnosis. At that time the mother was already in the first trimester of her fifth pregnancy. There were already three other children living besides Norma. The embryo did not survive. Not only was Mr. N. shocked, and grief-stricken, and withdrawn from Norma, but the child was also burdened by placement in the care of an aunt and uncle who were harsh and inconsistent. Fourteen months later the father married a widow who herself had a large family so that there were a combination of ten children in the amalgamated household. Furthermore, a year later, when Norma was seven years and eleven months, a cherished maternal uncle died in an automobile crash. He plunged off an eroded embankment in his automobile, his body never being recovered from the river below. When Norma was nine, her father was threatened with the possible loss of business opportunity, and it was in this setting of his continued pre-occupation with business difficulties that her presenting complaints arose.

From the beginning of our work together, the parents were told that the focus of the treatment was to enable Norma to feel more confident of her thoughts and feelings, not to lead such a socially isolated life, nor approach adulthood so frightened of being a woman.

The therapeutic alliance and focus with the child and her family moved to the bereavement following an introductory, supportive phase of approximately three months. She was seen weekly. From the third month on, Norma's treatment involved her questioning about, remembering, and missing people she had loved and lost, especially her first mother and her uncle. She expressed happy and sad affects appropriately,

focusing on the past, the present, and their connections. External events were usefully dwelled upon. They included separations from the therapist for the patient's and for the therapist's vacations, many cancelled or missed appointments, and two anniversaries of the first mother's death, and the first anniversary of the hysterical episode. Other interpreted loss reactions were the anniversary of beginning treatment. Termination was planned 7 months ahead. During that period, the child brought the therapist fantasies and misperceptions, using her as a nidus for her crystallizing attempts to identify with an adult woman's life. Transference envy, curiosities and jealous reactions were identified and interpreted as pertaining to the unresolved guilty oedipal relationship to the mysterious, increasingly remembered first mother and to the present mother. Connections were made through the transference reactions to experiences and misunderstandings of the past. Present intellectual misunderstandings were connected to their forerunners in confusing periods of early childhood. Feminine identification grew, and from wishing to be childless, Norma began a mild then vivid interest in heterosexual escapades acceptable to her family. Her gait, dress, voice and interests became those of a fully girlish early adolescent.

Phenomena of the last session are of special interest. The patient developed and recovered from an interpreted amnesia concerning the date of termination. She mastered a dread of saying goodbye, which was interpreted genetically in terms of her mother's death as a goodbye. She became aware of a curious uneasiness about looking up at the building in which the therapist's office was located--a phenomenon related to her waving goodbye to her dying mother in the upper floors of a hospital. At last, in the very last session there emerged a major connection between being feminine and dying: It emerged as a last-minute, never before expressed question, just in time to be clarified:

> "Did my mother die because she was having a baby?"

<u>The Special Problems of Double Orphans</u>:

Proceeding further into seldom explored areas of bereavement research, our experience with double orphans still is limited. One was seen in our Cornerstone Project and one, a twelve year old boy, was seen individually twice a week for several months.

Their immediate grief tended to be open, in the literal sense of prolonged anguished crying. Conscious feelings of grief also attended later remembering of the dead parents, more openly and more frequently than with orphans bereaved of one parent. Although causally different, the phenomenologic situation of double orphans is like that of Loretta Bender's psychotic orphans (8), who grieved profusely and even wildly. The double orphans, like psychotic children, lack adequate defenses, but the lack is in proportion to the great quantity of affect being stimulated by the double loss rather than because of the intrinsic deficiency of defense. Or in Hartman's terms we could say the proportional relationship of affect to defense is disturbed by excess over the "average expectable" life strain rather than by the inadequacy of their defenses due to any disease. But the double orphans may also have suffered some actual weakening or exhaustion of defense due to the first loss, on which the second loss is now heaped. The task with double orphans is therefore how to facilitate the management of extraordinary quantities of affect becoming detached from two major objects, and specifically how to manage this task without the development of gross deformities and breaches in the testing of perception, and in the adaptation to new objects. One of our two treated double orphans would frequently hallucinate. This was a major presenting problem, although in follow-ups he was not apparently psychotic. One task with that four year old boy was to provide interpretations to produce a framework of insight, so that he could understand the nature of his hallucinations, especially their wishful, loneliness-induced origin. In our twelve year old double orphan, a main accomplishment was to allow more boldness in his adaptation to peer social objects. His high dose of affectively charged conscious memories of both parents became more manageable when catharsis occurred repeatedly in twice a week sessions over a 10 week period. His love-life had been confined for one post-bereavement year to going over the parental memories, morbidly poring over photo albums, prolongedly weeping silent tears of regret for the now idealized life they had together with him. After catharsis in treatment the mournful ruminations diminished and social life increased, apparently using the now more available libido.

The Cornerstone Project:

Before discussing this most unusual of our techniques

with bereaved children, a fascinating technique for mourning facilitation developed and used with adults in Mexico is helpful to mention as an introduction. Remus-Araico (9), has reported excellent results with a series of twelve adult analysands orphaned during childhood. They generally suffered from repressed sad affect, and fixation to developmental stages at which the childhood bereavement had occurred, with evidence of a "traumatic neurotic" process. Not only do Araico's data confirm and enrich the finding of Fleming and her co-workers (10) in Chicago, they also provide an interesting innovative contribution to the facilitation technique. That contribution is in the form of what Araico calls "timeless interviews." He found it very useful to arrange that several times during the course of analysis he would meet with the patient for an interview whose duration was limited only by the interest and willingness of the patient and analyst to continue. These interviews, which frequently endured several hours, induced a state of remembering with extremely intense detail and high charge of emotion. Araico frequently felt the analyst and patient "were standing at the side of the grave together." We believe that such cathartic remembering is indeed difficult to facilitate in adults as well as in children. Yet to some extent it appears feasible even in children of pre-school age, as well as those who are older. A necess ry condition is a positive transference and ample time in which to set the mental stage.

One of the techniques used by the authors involves working 15 hours a week with orphans in a preventively-oriented nursery school, where the analyst is present in the classroom for six of those hours. This technique appears powerful and has been used for neurotic and psychotic children, as well as to give psychological aid to orphans of pre-school age. While the teachers conduct educational activities, the analyst works right in the congenial and communication-evocative setting. He transacts with one child and then moves on to work with another and another. In this setting he is able to interpret material the children express to teachers or to each other, as well as the play and verbal communications made directly to him. When the analyst leaves the classroom after an hour and a half of work each morning, the six or more child patients who constitute the class remain at work with their teachers.

The teachers* are well trained specialists in early childhood education, working under the analyst's supervision**, as well as the supervision of an educational director***. They observe and cultivate, but do not interpret the communications of the children made after the analyst leaves. Thus, while the classroom work continues for the remaining hours of the morning, many fantasies and playful expressions set in motion by the interpretive work of the first 90 minutes continue to emerge and are later reported to the children's analyst. At the same time, these expressions are channeled into ego-building social and educational activities.

We have now worked with about 30 children by this method, and are preparing a documentation of the procedure demonstrating that many essential features of a regular child analysis tend to occur despite the unorthodox setting. With the six orphans among our Cornerstone patients, a considerable amount of vivid, affectively expressive and ideationally rich energetic mourning work takes place. We mean to include in this emphatic statement all elements of Freud's Mourning and Melancholia definition, the working over of ideas and affects associated with the lost object, the cathecting and decathecting of the mental representative of that object, testing of the reality of the object's permanent absence, increased identification with the lost object, and use of liberated cathexis for investment in new objects. (1)

Time and time again, in the Cornerstone Project's daily sessions with orphans we find that the child's feelings and thoughts about the analyst are clearly and continuously linked to thoughts, memories, and feelings about the dead parent. Even thoughts about extremely frightening and shocking experiences in the past can emerge in the classroom setting, as part of the transference-linked working over. An example is provided by Quentin, a five year old who

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was with his father alone in a car when the father had a fatal heart attack and died in the boy's solitary presence. Quentin entered the Cornerstone Project about six months later, and the following excerpt from his work shows some of the interplay between the pathogenic past and the transference present:

> Quentin went to a great deal of trouble to pull the analyst's beard, and made a drawing of the analyst with a very long beard. The analyst was required to help, and to depict Quentin going for a ride on the analyst's beard, straddling the beard. Quentin then began playing automobile riding games and speaking of his father. He placed some paint in a bowl of water and said it reminded him of hair when the paint extended itself as strands in the clear water. Then it reminded him of blood, saying, "This is very dangerous. It's my Daddy's blood." Continuing to develop the blood theme, Quentin thought about how the blood in a person's heart could stop moving and then a scientist could stick the person in the heart to make it work again. He spoke of good and bad scientists and whether other things besides caterpillars could go into a cocoon and come out butterflies.

Up to this point, we can see that the analyst's person, particularly his beard, was transitional in the series that led to his father and thoughts of his father's death and fantasies of metamorphosis or reincarnation. Quentin proceeded to thoughts about cars crashing, wondering if his now late school bus had been in a crash, and what that would sound like. He grew tired, wanted to nap, and draped some play jewels over his head.

> They were "the flowers you put on a dead person." Lying very quietly he then said, "Would you be sad if a friend died?", hastening to explain:
>
> > "I thought my daddy was fooling, I asked the man who came if Daddy was alive or dead, but I thought he was just fooling, but he wasn't."

The next day Quentin demonstrated a marked continuity of theme in his Cornerstone work, and approached the teacher with the same colored beads, this time

announcing:

"I'm an angel."

Briefly recapitulating the work of the previous day, for Quentin, to let him know of the relevance to this remark, the analyst was then met with further details of the fatal episode:

"A man came and pulled me by the shoulders and I cried."

The analyst interpreted that Quentin must have wanted to stay with his Daddy and was still hoping that his Daddy was just fooling. The child responded with some further ideas about needles that could start a heart working again, which the analyst interpreted as thoughts which come because it would have been wonderful if Quentin could still have his father living, and Quentin would like to be a person who could have saved his father. In response, Quentin had two sets of thoughts:

First, Quentin asked if the school could get him an oxygen gauge, which he wanted to keep in the doll house he was now furnishing.

Then he spoke of houses which are nice and houses which are not nice; scientists who are good and scientists who are bad. Scientists who are good save people and scientists who are bad keep people tied up.

In later work, as well as some previous work, this theme of goodness and badness had been interpretable in terms of his anger at the father for having left him by dying, and his dread that if the father knew how angry Quentin was, the father would be angry at Quentin. The Cornerstone work proceeded, with increasing clarity of linkage and equation between the father and the male analyst, who was openly loved and died many times in the child's fantasies. Clinical improvement was marked, and rather parallel to the development of the mourning and transference process.

Evocation of Yearnings for an Unknown Father:

The opportunity to work with a posthumous child is rare. It was approximated by the presence in the school of a child who had suffered the death of his father at several weeks of age. He had never actually known his father, and it is of some interest

to note the vicissitudes of his work, by means of which he arrived at a useful awareness of what was missing in his life. The presence of a man analyst, within a heterosexual team of constructively collaborating adults, was probably a facilitator of his yearnings. In that emotionally nourishing setting, where his need for a father was to some extent really met by the frequent presence of the analyst, he could dare to let the yearnings emerge. The procedure is, of course, not strictly the same as the work of helping a child mourn for a loved person he has actually known, but is reported because of its relevance to the general problem of childhood bereavement.

David entered the Cornerstone Nursery at the age of three years, five months. Not only had he been paternally bereaved several weeks after birth, but his mother also had a chronic, presumably fatal illness. His two brothers were two and five years older than he.

This was a family in which a great deal of high drama went on, but always in terms of actions, veiled hints, without direct acceptance, recognition of or communication of these matters between the various people. Issues regarding death, separation, being left behind, came up rapidly and in many ways during the first year of David's treatment. Unfortunately, the first year proved to be the last at Cornerstone because of the threat which David's dealing with this material posed to the other members of the family.

Initially, the matter of separation from the mother arose. This was a mother who wanted to leave immediately, found it an intolerable burden to have to put in time staying with David in school. She was constantly referring to the issues of being there or not being there, and separation, but always in a displaced fashion, not directly relating it to the bereavement or to her own illness. She would do this with jokes. When David was shy one day, hiding behind his mother's skirts rather than relate directly to the teachers, she made the joke, "I think I left David at home today." This reference to his being elsewhere, not being there or being lost, was repeated in many many ways.

We did insist that the mother stay on with David a bit for several weeks rather than abruptly separate. During that time, he focused repeatedly on his fear of her leaving. It was possible to point

out to him his sadness, his fearfulness, his sudden non-involvement when she would be away. This was sufficiently helpful so that when his mother did separate he was able to stand it. David's concern about people being sick or away came up with a shocked reaction whenever anyone was ill. If a teacher, a therapist or other children were away, David was very upset and this upset was also pointed out to him in terms of his being worried about something happening to people. When his mother went for a periodic examination at the hospital, he was also upset and focused on the fear that something would happen to the mother. The analyst discussed the child's awareness of the mother's being followed in the hospital because of an illness, which, however, was being treated and attended to as much as possible. His own concern about his own body integrity came up in terms of his worries about his own physical examination, linked to thoughts of his mother.

The actual fact of David's father's being absent and of his missing his father came up for the first time some months after he had been in the nursery. This was a completely avoided subject before then, and when the patient finally brought it up at home his older brother's reaction was to turn to the mother and say, "Mom, this kid's nuts." In school, David made a magic potion of mud, dirt, water and paint. He was able to express exactly what the magic potion was in terms of, "Magic to bring a father back." He was able to express his loneliness for his father at this point, and his wish for a father as expressed in this magic potion. He built a snow man outside and when a few of the children broke it down, he showed real despair, and great upset. He said that this was a real man, and the analyst pointed out to him that he wished so much that he could have a real man, like a father, that when his substitute for the real man, namely the snowman, was destroyed, he missed it badly. He was able to agree with and seemed relieved by the interpretation.

There followed a change from his typical way of functioning. Initially, he would behave like a puffed up big little man, talking in a loud voice, denying anxiety and depression, instigating fights, being like a little sheriff in the classroom. Thereafter, he was able, after admitting his sadness and his missing having a father, to be more of a little boy with a little boy's needing of his father, missing of the father, and sadness about

not having the father. There ensued a playing of games with the therapist in which they would eat together, prepare meals together, and trade gold with one another. Much of the work seemed related to his very much longed for process of identification with a father or a male.

Vacations were hard for all the children, as were holidays, and he found them difficult, too, in line with material discussed above. Transference interpretations were made in terms of David having to be tougher, more abusive, and less communicative following and just before vacations and holidays. In response he showed minimal changes initially, but then more directly demanded the therapist's attention and less directly avoided it.

For a long time this rough, tough little man had needed to deny positive feelings towards the analyst. He referred to the analyst as stupid or dootie. After the interpretation of missing the father, wanting to make a father through the magic potion or the snowman, when he was able to become more of a little boy, he was also able at times to directly express his positive feelings towards the analyst. This change came in spite of maternal and familial mode of expressing a feeling in terms of the roughness, the toughness, the mechanical loud busyness. He dropped much of this and became a little boy wanting to play a game of identifying (mentioned above) with me.

Technical Separation Reactions as Facilitators of Mourning:

In one case treated in the Cornerstone Project there was an unexpected necessity to suddenly help a child deal with the death of his father. The death occurred as a result of a railroad crash and the child had already been acquainted with the analyst and the teachers for six weeks prior. He had been attending the Cornerstone school because of problems of transvestism and aggressive behavior. A feature of his immediate reactions to the death of his father was a combination of heightened positive transference with considerable expression of sad affect in yearning for the return of his father. The child made steady clinical progress, overcoming the transvestism and aggressive behavior and experiencing a rather vigorous mourning process, including conscious and unconscious identifications with his

father, much remembering associated with sad affect, and a gradual giving up of consciously expressed hopes for the father's return. Throughout the treatment process a major feature was close attachment to the male analyst, as well as female teachers. In retrospect it seems that the prolonged presence of a heterosexual team, and especially the many-hours presence of a real male substitute for the lost male parent, permitted the expression of what might otherwise have been an unbearable yearning and sense of emptiness in his life. This child expressed his sadness upon the death of his father both overtly at a conscious level and in multiform unconscious expressions at a level of symbolic verbal playful creative and dream activities. The father's death appeared to increase the intensity of transference to both teachers and the analyst. Simultaneously, with passionate attachments to the therapeutic team members, Jay dwelled on thoughts of his lost father, experiencing powerful sadness and increasing identification with the father's traits. His clinical progress was excellent after two years in the school, and he continued working with the analyst twice a week on a regular individual basis thereafter.

His experience when the treatment was to be reduced still further is dramatic evidence of how a bereaved child is disturbed by the resonance of treatment separations with personal history of separations and loss.

At the end of 3 years treatment, Jay and the analyst discussed his progress and made plans for a vacation and then reduction of treatment from twice to once a week. At that point Jay, who had been speaking of how well he felt he was doing in school and socially, experienced a momentary near loss of balance, as he was perched on a worktable, reaching up to a high shelf. He became frightened that he was to fall, and the analyst moved over toward him, saying that this was a way of letting us know that he still needed help with his accident trouble, which he had been talking about quite a bit lately. Jay said that it sure was a trouble that he needed help with. In a few moments Jay said he was frightened because he was seeing "a dark shadow man" in the doorway, adding, "I think I'm having hallucinations." "I get this feeling when I look into a dark room or a closet, or I walk by a doorway, the feeling that I'm seeing a dark shadow man in there--a scary man."

Jay and the analyst then discussed the way this "hallucination" had come up when talking about something that would make Jay lonely for the analyst--not seeing him in his office. At first Jay denied there was any connection, but then further elaborated his fearfulness, saying that he also sometimes was afraid that he was having hallucinations because on a couple of occasions he thought he was seeing flying saucers--once at night and once in the middle of a foggy day. Again the analyst reminded Jay of the connection previously established to lonely feelings and outer space monsters, a connection which at first Jay denied by saying that the fears had started before his father died, and they also came on when he did not feel lonely. Later he said it funny though, that it had come on when talking about not seeing the analyst as often. He would not like that. He wanted to come more often, three times a week, at least twice a week, and not just once a week.

The session ended with Jay feeling much more relaxed and clearly aware that he feared and resented the reduction in treatment but could tolerate it.

This appears to be an example of transference neurosis with hallucinatory experience, facilitated by a separation pending in the form of a vacation to be followed by a reduction in frequency of sessions. There was technical utility provided by the separation, which could be analyzed in the light of the transference from father to analyst. The symptom of flying saucer and outer space men fears in the child's life was transferred into the analytic session and appeared specifically in relation to the separation experience, which could thus be better understood by the child because of its narrow framework.

Cornerstone Work with a Double Orphan:

Marvin, age four years and six months at onset of treatment, was from an impoverished black family where both parents were physically ill for several years. His mother died of chronic hypertension and a cardiac failure when Marvin was three years eleven months. His father, who had been a kidney disease invalid and home bound most of Marvin's life, died only one month after the mother.

Compounding the tragic fracturing of Marvin's life had been severe prior stress. Especially pathogenic had been his mother's insidious dementia as she

succumbed to hypertension. Becoming a recluse, suspicious of visitors to her sad and increasingly unkempt home, she failed to toilet train her children, who often ran naked and excreted on the floor.

While shopping she would leave the children in the care of their weakening, bed-bound, and finally blind father. On one such dreary occasion, Marvin and his one year older sister played with matches under the stove and set a blaze which brought the fire department before any serious damage occurred. Neighbors and firemen who rescued the helpless father and children called the SPCC on finding the floors strewn with old feces.

The deaths occurred a few months later. His maternal grandmother, freed then from the prohibiting suspicions of her now deceased daughter, then came to assume the care of the two children. They were at that time, nearly feral. Marvin was almost without useful language as well as untrained. Soon enrolled in a daycare center, Marvin was disruptive, restless, and ummanageably aggressive. Referred to Cornerstone, initial examination revealed him to be agitated, incoherent, and anxiously responding to hallucinations seen on the classroom ceiling.

In the first five months at Cornerstone, Marvin frequently continued to hallucinate, and spoke of fire in the ceiling. He gradually became very attached to the analyst, the teachers, and the black handyman. The hallucinations cleared concurrently with completion of the first major interpretative work. This work was that when Marvin began to misidentify the black handyman as his father, the analyst was able gradually to interpret the lonely wishful quality of the delusion. Marvin was then able to cling physically to the teachers, whom he called "mother," in contrast to his formerly hostile and disruptive relations to teachers. The availability of new objects to whom Marvin could transfer some of his old investments of love appeared highly useful.

After five months with his first analyst*, the project's financial necessities required that the two groups in the project be reduced to one group.

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The remaining group had a different analyst**.

The transition was used with surprising advantage. Marvin insisted that the new analyst was really the first one. It was feasible to point out the similarity of this delusion to the handyman-father delusion. Thereupon Marvin began to speak to his grandmother and sister about how the first doctor "wasn't coming back anymore," and for the first time spoke of his mother and father in this same realistic way. It thus appeared to have been an assimilable experience to lose the first analyst. With the moderate dose of analyst loss, with a replacement immediately available, improved reality testing was feasible, and further growth occurred.

With the second analyst, obvious questing for the analyst as father occurred, with open anger, sadness, and weeping on many days when the analyst would end his 90 minute participation in the classroom procedures. The small daily dose of loss was digestible with the sweetening vehicle of two maternal teachers who remained during and after the analyst's presence. Genetic interpretation of the transference expressions of protests and sadnesses led to many relevant memories being evoked of Marvin's life with his parents, charged with protest and anguished grief over their absence. The process of identification with some of their now-remembered activities and traits was clear. For a while a feminine identity trend began to hold sway, with powerful yearning to learn to cook in school, dressing in ladies clothes, speaking of the wonderful pies, cakes, and pancakes his mother used to make for him.

At this point a remarkable synergism of educational and analytic techniques occurred, probably unique to the Cornerstone situation. The teachers helped Marvin learn to cook, while the analyst helped him understand his wish to have mother inside him and become like her so that he would not be lonely for her. This work led to his falling in love with the teachers, his sister and grandmother, all of whom he wished to marry. He then became very focused on one teacher and one girl in the Cornerstone group, making many gentlemanly and some not so refined romantic overtures and voyeuristic approaches.

Marvin's intellectual development then proceeded vigorously, as he reached the genital phase. He now

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appears nonpsychotic and of superior intelligence. After 14 months in the Project he has gone into a public school. The details of his exuberantly productive work with the analyst and teachers will fill a book. But no aspects were so important as the dynamic and genetic interpretations of transference separation reactions mentioned, which may be viewed as therapeutic induction use of situations of grief.

Discussion and Conclusion:

There is general agreement that the process of mourning, as Freud defined it in Mourning and Melancholia, is much more difficult and often much less complete for young children than it is for adolescents and adults. Some believe that successful or complete mourning is not possible until adolescence. We hope we have documented reasons for an optimistic view when intervention occurs to facilitate the process.

We also view optimistically the immediate treatability and analyzability of bereaved children.

In his Analysis Terminable and Interminable (15), Sigmund Freud emphatically stated that psychoanalysis proceeds most effectively "if the patient's pathogenic experiences belong to the past, so that his ego can stand at a distance from them. In states of acute crisis analysis is to all intents and purposes unusable. The ego's whole interests are taken up by the painful reality and it withholds itself from analysis, which is attempting to go below the surface and uncover the influences of the past."

Many analysts today still believe that adults should not be taken into analysis in the midst of an ongoing love affair, or after the death of a loved person, especially during the period of acute mourning. Anna Freud goes further and suggests that child analysis will be less effective than ordinarily to the degree that "the threat, the attacker or the seducer is a real person, in contrast to situations where the child's fears, fights, crises and conflicts are the product of his inner world." (16)

We would like to present a somewhat different conclusion than Sigmund Freud and Anna Freud have reached, although based upon reasoning which is similar up to a point. It is our experience, especially with children of very young age, but also with adults and adolescents who have been in acute bereavement situations, that this crisis itself

often forces or facilitates the tendency of a person to go below the surface of his daily conscious life and deal inexorably and regressively with influences of the past. The particular crisis seems an exceptionally powerful potentiator of the emergence of the past, and therefore, we submit, makes the patient--adult and child alike--unusually available if the therapist is willing to accept the full range of communications brought to him and deal with them unflinchingly as material for scrutiny rather than as reasons to reject the task. Indeed, we would draw the attention of analysts to the exceptionally strong disposition of crisis patients to form strong transferences which develop rapidly and are not only best handled with analytic technique but also can facilitate such an approach.

The flow of love and hate in transference provides an exceptional opportunity for a patient to experience manageable doses of the same emotions he experienced with love and hate objects in real life outside of treatment. The therapeutic situation, whether by design or not, usually imposes new demands for reaction to loss. When the loss reactions occurring in treatment are deliberately scrutinized and focused upon, a bereaved child has a new chance to work through the reaction to the death of a parent, because the transferred reaction is more easily bearable. Because the transferred reaction is subjected to interpretation, the child has an increased repertoire of means at his disposal for mastery, including mourning and going forward with life's new tasks.

In other respects, we are fully in agreement with Anna Freud, who stated in 1968 (16) that we still cannot know how far the neglect of developmental needs can be undone by treatment. She apparently includes in this suspension of judgment how far the absence of a parent and its myriad consequences may be undone by treatment. In a situation such as parent loss, she points out, therapists may be unwilling to restrict themselves to analysis and may find other avenues of approach. One such approach is turning the treatment situation itself into an "improved version of the child's initial environment, and within this framework aim at the belated fulfillment of the neglected developmental needs." Another approach is an endeavor to share the work with parents, who may be able to undo some of the harm they have caused. In the Cornerstone Method and in some of our other methods, we have certainly used the first modification to an extent. With some cases we have added considerable effort

to induce a change in the surviving parent's behavior, particularly where fresh pathogenic insult was added to the previous loss. This is true, for example, when a parent begins a dangerously seductive custom.

After so much technical detail, we would like to close on a missionary note. It is our expectation that a great deal more can be done in the prevention of mental illness than has been attempted so feebly up to this point. As a profession of healers we have shown an extraordinary prejudice for the treatment of those who are far advanced in their need for healing. We have shown little energy with those who are still under the formative influence of the original damaging forces. The younger a patient is, indeed, the less likely he is to receive our profession's attention.

A prime target for the development of assessible services in the prevention of mental illnesses is any homogeneous early-age group which suffers from a common variable likely to increase the incidence of psychopathology. Such a group can readily be found among bereaved or one parent children entering nursery, headstart, or daycare systems. For this reason, we emphasize the Cornerstone services as a means to multiply efficiency in use of psychiatric hours, making preventive efforts practical.

We are prepared to go further in missionary zeal and express the opinion that parent guidance has not received adequate scientific opportunity for assessment of effectiveness. It should be assessed in situation likely to yield a very high incidence of pathology in untreated states. We further submit that programs of even more superficial approach, such as parent education without guidance, also have been prematurely written off as hopelessly weak and ineffective.

Unless we systematically explore, control, and assess the effectiveness of applied psychoanalytically oriented means for large-scale prevention, we shall have defaulted in using the most obvious measures while immersing ourselves mainly in matters of great professional fascination without great hope of social yield.

So far as our Center's projects for the immediate future are concerned, we are beginning to expand the applications of the Cornerstone Project and its derivatives. Thus, more children can be worked with

under psychiatric leadership, having the advantage of teachers to assist in guidance and as auxiliaries in the receptive aspects of interpretive therapy. We also persist in evolving still more widely utilizable procedures, still based on psychoanalytic knowledge, but less intensively interpretive. Thus, we hope to have control groups while answering questions concerning feasibility of prevention. We are now developing a program which will give preventive services to one hundred pre-school children in situational crises each year. The focus will be on a narrow range of age population, suffering from a few pathogenic factors in common. The assessment problems will be greatly reduced because of the homogeneous age combined with the uniformity of pathogenic variables. It may be particularly feasible in one large metropolitan area to assemble a group of pre-school boys all of whom are paternal orphans, to be treated by two different methods. It is our belief that some of the best hopes for the future of psychiatry and psychoanalysis lie in such scientific and social opportunities, making scrupulous efforts to phrase some of our questions in answerable form.

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